STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	001147	A. BUILDING: _____ B. WING _____	10/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY REST HOME	10924 LINCOLNWAY E PLYMOUTH, IN 46563

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: October 21 and 22, 2013 Facility Number: 001147 Provider Number: 001147 AIM Number: N/A Survey Team: Lora Swanson, RN-TC Debora Kammeyer, RN Julie Wagoner, RN (10/22, 2013) Census bed type: Residential: 40 Total: 40 Census payor type: Medicaid: 40 Total: 40 Sample: 8 Shady Rest Home was found to be in compliance with 410 IAC 16.2 in regards to the State Residential Licensure Survey. Quality Review 10/23/13 by Lisa McColly	R 000		